Department of Employee Trust Funds
Wisconsin Retirement System
P.O. Box 7931
Madison, WI 53707-7931

EMPLOYER STATEMENT

Wis. Stat. § 40.63

Employee Name	Social Security Number

Your employee has applied for a disability benefit from the Wisconsin Retirement System. The Department is in the process of reviewing the individual's application. Please complete the following information:

1. Date employee last rendered services _____ (*see second page for explanation*)

2. Are there any earnings payable after the date last rendered services? ☐ Yes ☐ No
   If yes, please identify payments that extend the last day paid _____

   _____

3. Last day paid _____ *(see second page for explanation)*

4. Is the employee expected to resume active service? ☐ Yes (date expected to resume service_____) ☐ No

5. Do you as an employer wish to contest this employee's application for disability benefits? A "Yes" answer will result in a denial of the disability application. ☐ Yes ☐ No
   If yes, state your reason(s): _____

   _____

6. If employee is an elected official indicate the date of the end of the official's term of office: _____

7. Please report termination date and hours and earnings that have not previously been reported to the Department in the space provided below:

Employer Name	Employer Identification Number	Report Date (MM/DD/CCYY)
	69-036-	

			Teachers/Judges/Educ. Support Personnel Only 1-1-XX thru 6-30-XX		**Calendar Year-to-Date (All Employees, including Teachers, Judges & Educ. Support Personnel)**		**Deducted from Employee**		**Add'l Contr? X if Yes**
Emp Cat.	Action Code	Termination/Action Date (MM/DD/CCYY)	Fiscal Hrs. Of Service	Fiscal Earnings	Calendar Hrs. of Service	Calendar Earnings	Employee Required Contribution	Benefit Adjustment Contribution	

Please return this form to the Department within thirty (30) days of receipt to avoid delays in processing the individual's application.

I understand that Wis. Stat. § 943.395 provide penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. Employer representative signing this form attests to being the WRS Agent's Designee authorized to sign.		
Date (MM/DD/CCYY)	Signature of WRS Agent, Agent's Designee or Certifying Officer	Telephone Number

INSTRUCTIONS TO EMPLOYER

The person named on the reverse side of this form is applying for a disability benefit from the Wisconsin Retirement System.

DATE EMPLOYEE LAST RENDERED SERVICES – Enter the last day worked. Last rendered services means most recently performed actual work for which entitled to earnings excluding any subsequent period on sick leave, other paid leave, vacation, compensatory time or worker's compensation temporary disability benefits.

LAST DAY PAID – Last day for which paid means the most recent date for which the employee was paid earnings, including accumulated sick leave, other paid leave, vacation, compensatory time or worker's compensation temporary disability benefit which may result in the last day paid being subsequent to the date the employee last rendered services. This date is not the date of the employee's last check.

* If your compensation plan or contract provides for conversion of accumulated unused sick leave to pay health insurance premiums, your employee who is approved for the disability benefit can begin the benefit at an earlier date by converting the unused sick leave to credits for the payment of the employee's group health insurance premiums.

For WRS disability purposes only, the last day for which earnings (including vacation pay, sick leave* or compensatory time) have been or will be paid is deemed to be the termination date. This date establishes the earliest annuity effective date.

NOTE: You must also report the employee's last day for which paid and final service and earnings in accordance with the *WRS Employer Administration Manual*, Chapters 8 or 14. If you have reported the final earnings and service, we will update the individual's account with the last day paid and termination date as reported on the reverse side of this form. **This employee's benefit will not be paid until this information is reported to the Department.**